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03 June 2011

Version of attached file:

Published Version

Peer-review status of attached file:

Peer-reviewed

Citation for published item:

Cook, C. C. H. (2008) 'Spirituality and alcohol dependence.', in Identification and treatment of alcohol dependency. Keswick: M K Update, pp. 289-302.

Further information on publisher's website:

<http://www.mkupdate.co.uk>

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Identification and Treatment of Alcohol Dependency

Edited by Colin R. Martin



Foreword by
Professor Dame Betty Kershaw



Identification and Treatment of Alcohol Dependency

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Edited by

Colin R. Martin RN BSc PhD YCAP CPsychol CSci AFBPsS

Chair in Mental Health, University of the West of Scotland, Ayr, Scotland

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ISBN: 978-1-905539-16-1

First published 2008

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British Library Catalogue in Publication Data

A catalogue record for this book is available from the British Library

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To contact M&K Publishing write to:

M&K Update Ltd · The Old Bakery · St. John's Street

Keswick · Cumbria CA12 5AS

Tel: 01768 773030 · Fax: 01768 781099

publishing@mkupdate.co.uk

www.mkupdate.co.uk

Designed and typeset in 11/13 Candara by S. Maria Hampshire.

Cover and graphics by Luke Kelsey.

Printed in England by Reed's Printers Ltd.

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Spirituality and alcohol dependence

Christopher C.H. Cook

Why should there be a chapter on spirituality in a book on the identification and treatment of alcohol dependence? There is no mention of spirituality in either the DSM-IV (American Psychiatric Association, 1994) or ICD-10 (World Health Organization, 1992) criteria for alcohol dependence, and neither is spirituality to be found in any of the major screening questionnaires used to identify cases of alcohol dependence. Further, it might be argued, many treatment programmes for people with alcohol dependence do not include any explicitly spiritual intervention in their therapeutic regimen. Perhaps the real reason for surprise, however, is that since the ‘Enlightenment’, science and religion have conducted their discourse in different seminar rooms and in different publications. (The ‘Enlightenment’ refers here to the intellectual movement that began in the 17th century, which emphasised reason as the basis for belief and thus excluded the authority of sacred texts and religious traditions; see Honderich, 1995, pp.236–37.) It has not been at all usual, at least not until very recently, to find material on subjects such as faith, religion or spirituality in scientific publications, and this is despite the publication of William James’ seminal work on the psychology of religion over a century ago (James, 1985; originally published in 1902). Science focuses objectively on reason and evidence, spirituality and religion (at least, so it is argued) on the subjective, intangible and unprovable.

While spirituality is not explicitly mentioned in either DSM-IV or ICD-10, it is increasingly being argued that addiction – alcohol dependence included – is in fact a spiritual disorder, or at least that there is a spiritual dimension to it (e.g. May, 2000). While screening questionnaires do not currently include items on spirituality, the scientific assessment of spirituality by questionnaire or interview is an increasing concern of research in the addictions (Cook, 2004; Miller, 1998). Furthermore, addiction treatment programmes can, and do, incorporate spirituality into their therapeutic work (Jackson and Cook, 2005; Ringwald, 2002). Perhaps most importantly, the history of the so-called ‘12-Step’ mutual help movement, based on the pioneering work of the founders of Alcoholics Anonymous (AA), has had a deep impact on addictions treatment worldwide and cannot be ignored in any serious analysis of the identification and treatment of alcohol dependence. While faith-based treatment and rehabilitation programmes have also

been very important on the international treatment scene, it is probably Alcoholics Anonymous that has done most to put spirituality on the addictions treatment agenda. However, spirituality and religion have become an increasing concern in all areas of healthcare research in recent years (Koenig, 2005). The Spirituality Interest Group of the Royal College of Psychiatrists in the UK has grown to be one of the most popular groups within that College (Powell and Cook, 2006), and service users are increasingly demanding adequate attention to their spiritual, as well as their psychological, social and physical needs (Mental Health Foundation, 2002). For all of these reasons, and whatever conclusions might be reached by a particular reader or author about the merits or demerits of spirituality as a clinical and research variable, a book on the identification and treatment of alcohol dependence might now be considered incomplete without at least some attention being devoted to this subject. However, one of the major criticisms of work in this field has been that it is impossible to define spirituality scientifically, and/or that it is in fact a multidimensional concept which fragments into different components when subjected to careful analysis. We must therefore begin by giving attention to the *definition* of spirituality.

Definition of spirituality

There is no doubt that definitions and descriptions of spirituality, even within the addictions literature, vary widely. It is commonly defined as distinct from religion, usually on the basis of experience. For example, Berenson (1990, p.59) states that: 'Spirituality, as opposed to religion, connotes a direct, personal experience of the sacred unmediated by particular belief systems prescribed by dogma or by hierarchical structures of priests, ministers, rabbis, or gurus'. Others come to the contrary conclusion (Mercadante, 1996, p.13) thus: 'Spirituality by definition is supported or formed by conceptual and religious structure'. Commonly, reference is made to personal relationships, and especially to relationships with some kind of transcendent order, or God (Dollard, 1983, p.7): 'Spirituality... is concerned with our ability, through our attitudes and actions, to relate to others, to ourselves, and to God as we understand Him'. However, a variety of concepts are in fact brought into play by different authors. In a systematic review of these definitions and descriptions (Cook, 2004), thirteen such conceptual components of spirituality have been identified, as listed in Box 22.1.

Box 22.1 Thirteen conceptual components of spirituality (Cook, 2004)

- Relatedness
- Transcendence
- Humanity
- Core/force/soul
- Meaning/purpose
- Authenticity/truth
- Values
- Non-materiality
- (Non) religiousness
- Wholeness
- Self-knowledge
- Creativity
- Consciousness

In practice, relatedness and transcendence are the most commonly identified concepts. However, even if multidimensional assessment of spirituality as a variable might be warranted, it is not clear that the thirteen concepts are unrelated to each other. Therefore, a definition has been proposed by Cook (2004, pp. 548–49) as shown below.

A definition of spirituality (Cook, 2004)

Spirituality is a distinctive, potentially creative and universal dimension of human experience arising both within the inner subjective awareness of people and within communities, social groups and traditions. It may be experienced as relationship with that which is intimately 'inner', immanent and personal, within the self and others, and/or as relationship with that which is wholly 'other', transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth and values.

Numerous research instruments are currently available for the measurement of spirituality as a dependent or independent variable in addictions research (Cook, 2004; Hill and Hood 1999; Morgan, 2002). Obviously, the underlying concepts that inform the design of an instrument will influence its suitability for use in any particular research methodology. At least one validated measure is available which offers a multidimensional approach (Fetzer Institute and National Institute on Aging Working Group, 1999).

The history of spirituality

Spirituality is a relatively recent concept (Cook, 2004, pp. 539–40). Furthermore, it was only following the publication of the seminal works on drunkenness by Rush in 1785 (Rush, 1943) and Trotter in 1804 (Trotter, 1988) that the subject of alcohol dependence (as we now refer to it) became a focus of medical interest. Up until this time, at least in Christian Europe, alcohol consumption was a concern of theology and morality, but not of scientific interest (Cook, 2006). For a century or more it remained a subject of both religious and scientific concern but, as the Enlightenment increasingly relegated matters of religious concern to the private domain, and as secular discourse increasingly excluded theology, the focus changed. During the 20th century, alcohol dependence came to be regarded in medical and scientific circles as a bio-psycho-social syndrome (Edwards and Gross, 1976).

Of course, in other parts of the world, things might have been seen differently. For example, in contrast to Christianity, Islam has consistently proscribed the consumption of alcohol for centuries, largely on the basis of what we might now call concerns of spirituality: in particular the adverse effects of alcohol on social relationships and prayer (Cook, 2006, pp. 11–12). Buddhism, on the other hand, understands the suffering associated with addiction within the broader context of human suffering, and spiritual resources within that faith tradition are increasingly being explicitly applied in the treatment of alcohol dependence (Alexander 1997; Bien and Bien, 2002). In different parts of the world today, Christian (Moos, Mehren and Moos, 1978), Islamic (Abdel-Mawgood *et al.*, 1995), Buddhist (Barrett, 1997) and Native American (Garrett and Carroll,

2000) treatment programmes for alcohol dependence and/or other chemical dependencies incorporate spirituality into their therapy, each according to their own faith tradition. However, the emergence during the 20th century of spirituality as a significant concern in the treatment of alcohol dependence has been particularly related to the history of Alcoholics Anonymous and its spiritual – but not religious – approach to recovery.

Alcoholics Anonymous dates its origins from 10 June 1935, the day Dr Bob Smith, its cofounder, had his last drink (Alcoholics Anonymous, 1976, pp. 171–81). The origins of the society were very much concerned with the mutual help given by one alcoholic to another. However, in a classic account of the history of Alcoholics Anonymous, Ernest Kurtz notes that its roots were in both religion and medicine (Kurtz, 1991, p. 33). On the one hand, the religious roots may be traced to the involvement of its founders in the Oxford Group, an evangelical Christian movement of that time, the personal religious experiences of its founders, and the seminal work of William James, *The Varieties of Religious Experience*. On the other hand, they may be identified in the medical influences of Dr Carl Jung and Dr William Silkworth, not to mention that one of the cofounders was himself a surgeon. According to Kurtz, the core idea of Alcoholics Anonymous was concerned with the hopelessness of the condition and the sense of deflation that arose from this. From this ‘rock bottom’ position, the founders experienced a kind of conversion: from alcoholism to sobriety, and from destructive self-centredness to creative and human interaction with others (Kurtz, 1991, pp. 33–34).

That Alcoholics Anonymous came to identify itself as ‘spiritual rather than religious’ doubtless has much to do with the effects of Enlightenment rationalism, already referred to above, and also with the emphasis on personal experience rather than dogmatic religion (Kurtz, 1991, p. 175). Within the pages of *The Varieties of Religious Experience*, which was highly influential on the founders of Alcoholics Anonymous, are examples of how religious conversion can be associated with conversion from alcoholism to sobriety (James, 1985, pp. 201–03). William James emphasised throughout this book the common experiential components of religion; clearly he was no admirer of dogmatic tradition. Thus Alcoholics Anonymous inherited a very slightly ambivalent approach to religion. On the one hand there was a positive sense that religious experience could be a vehicle for recovery from alcoholism, and a largely positive experience of this within the specific tradition of the Oxford Group. On the other hand there was an implication that no particular religious tradition offered more than any other and that the institutional and doctrinal aspects of religion were at least not important, and possibly unhelpful.

Carl Jung also emphasised the need for a ‘vital spiritual experience’ as a pathway to recovery from severe alcoholism (Alcoholics Anonymous, 1976, pp. 26–27). It was this which formed the basis for his dictum, expressed many years later in a letter to Bill Wilson (the other cofounder of Alcoholics Anonymous), *spiritus contra spiritum*. Jeff Sandoz, a contemporary counsellor and retreat director, pointed out that this dictum can be interpreted both ways (Sandoz, 2004, pp. 44–45). That is, that alcohol (*spiritum*) can be detrimental to spirituality (*spiritus*) but spirituality can also act against alcohol dependence – to bring sobriety and healthy relationships with God and others.

It is this spirituality which has been affirmed within Alcoholics Anonymous, and it has been affirmed in such a way as to ensure that the organisation remains accessible to people from all religious traditions and none. Indeed, although objections that Alcoholics Anonymous is ‘too religious’ are not infrequently encountered among those who make excuses for not attending its meetings, its members include many agnostics, and even atheists, as well as practising

members of all the world's major faith traditions. Alcoholics Anonymous has been influential in the alcohol treatment field if only because of the large number of groups and members that it has accumulated worldwide. Arguably, it has done as much as any of the world's major faith traditions in terms of establishing the importance of a connection between addiction (especially alcohol addiction) and spirituality. However, Alcoholics Anonymous's concept of spirituality, which must now be understood as an almost completely secular spirituality, has flourished in a world in which interest in spirituality generally has been on the increase (Sheldrake, 2005, pp. 7–12). The spirituality of this age is very different to that of the world's historical faith traditions. It is pluralist, syncretistic, and blended with various strands of psychology and psychotherapy. However, it is clearly this interest in spirituality that has fuelled increasing numbers of scientific and medical publications on spirituality and healthcare (Cook, 2004).

Spirituality in clinical practice and recovery

What form might spiritual interventions, or spiritual components of treatment programmes, for alcohol dependence take? There are many possible answers to this question, which are as varied as answers to the broader question of what form any interventions for alcohol dependence might take. Some specific examples will be considered here. However, it is first important to note that some (perhaps many) people recover without any formal treatment, or even without any involvement in a mutual help group.

In his classic longitudinal study of the natural history of alcoholism, George Vaillant (Vaillant, 1983, pp. 190–91) found that religious involvement and Alcoholics Anonymous were sometimes reported as 'non-treatment' factors associated with finding a pathway to abstinence. In the case of 21 men achieving 'secure abstinence', 19 per cent mentioned the former, and 38 per cent the latter. However, at least five men in this study recognised 'mystical belief, prayer, and meditation' as being a 'substitute dependency'. Perhaps, then, spiritual and religious behaviours are in some way related – psychologically or otherwise – to the behaviours that are encountered in alcohol dependence? It has long been suggested that alcoholism is in fact a misguided search for God. In other words, spiritual and religious concerns lay at the heart of the psychodynamics of addiction. William James suggested that alcohol had the power to 'stimulate the mystical faculties of human nature' (James, 1985, p. 387), although he was not unaware that this was achieved at a cost:

Sobriety diminishes, discriminates, and says no; drunkenness expands, unites, and says yes. It is in fact the great exciter of the Yes function in man. It brings its votary from the chill periphery of things to the radiant core. It makes him for the moment one with truth. Not through mere perversity do men run after it. To the poor and the unlettered it stands in the place of symphony concerts and of literature; and it is part of the deeper mystery and tragedy of life that whiffs and gleams of something that we immediately recognise as excellent should be vouchsafed to so many of us only in the fleeting earlier phases of what in its totality is so degrading a poisoning.

More recently, and in more contemporary psychological language, Jeff Sandoz has argued that alcoholic intoxication induces a god-like euphoria in which illusions of power are associated with

tranquillisation of dysphoria (Sandoz, 2004, pp.36–37). If such intuitions are correct, then one might expect that the replacement of the pathological spirituality of the alcohol dependent state with a more healthy spirituality – whether that of Alcoholics Anonymous, or a religious tradition, or of some other kind – might be therapeutic. Such an objective might form the central focus of treatment, as for example in Alcoholics Anonymous, or else it might form only one component of an overall treatment programme, as for example based on the principles of relapse prevention (Moss *et al.*, 2007). But what form might therapy orientated towards such an objective take? Three examples of spiritually oriented therapy will be considered here: the mutual help programme of Alcoholics Anonymous, an explicitly Christian approach to working with alcohol-dependent people, and a spirituality group as a part of a comprehensive treatment programme provided within a secular medical healthcare setting.

Alcoholics Anonymous

The central principles of the programme (Alcoholics Anonymous, 1977) came to be written down as ‘12 Steps’ which the founding members took in the course of their own recovery. These are listed in Box 22.2.

Box 22.2 The 12 Steps of Alcoholics Anonymous

- | | |
|----------------|--|
| Step 1 | Admitted we were powerless over alcohol – that our lives had become unmanageable. |
| Step 2 | Came to believe that a Power greater than ourselves could restore us to sanity. |
| Step 3 | Made a decision to turn our will and our lives over to the care of God as we understood Him. |
| Step 4 | Made a searching and fearless moral inventory of ourselves. |
| Step 5 | Admitted to God, to ourselves and to another human being the exact nature of our wrongs. |
| Step 6 | Were entirely ready to have God remove all these defects of character. |
| Step 7 | Humbly asked Him to remove our shortcomings. |
| Step 8 | Made a list of all persons we had harmed, and became willing to make amends to them all. |
| Step 9 | Made direct amends to such people wherever possible, except when to do so would injure them or others. |
| Step 10 | Continued to take personal inventory, and when we were wrong, promptly admitted it. |
| Step 11 | Sought through prayer and meditation to improve our conscious contact with God as we understood Him praying only for knowledge of His will for us and the power to carry that out. |
| Step 12 | Having had a spiritual awakening as the result of these steps we tried to carry this message to alcoholic people and to practice these principles in all our affairs. |

The first three steps are concerned with a recognition that the alcoholic cannot help him or herself and that they therefore need to turn to a 'higher power', which in step 3 is explicitly referred to as God. This recognition of the need for a higher power – which may be conceived of in very non-theological terms as well as in traditional religious formulations – is fundamental to the spirituality of Alcoholics Anonymous. Steps 4 to 10 clearly reveal the Christian origins of the organisation, for they are very much concerned with confession and repentance. However, the language is of 'moral inventory', 'wrongs', 'defects' and 'shortcomings' rather than sin, and repentance is to be evidenced by a willingness to be changed, and a readiness to 'make amends'. Absolution and forgiveness are not in evidence; the importance of a desire to change and of taking of responsibility for one's own part in a recovery which God alone can bring about is the focus of concern. Steps 11 and 12 anchor the ongoing life of the recovered alcoholic in spiritual practices of prayer, meditation and reaching out to others. However, no specification is made as to what constitutes prayer or meditation. The emphasis here is on submission to God and concern for others. While Alcoholics Anonymous has become associated with a disease model of alcoholism, in fact the 12 Steps do not refer to this, but rather focus on the spiritual process of recovery. It is this process that is central, and all other matters are made subsidiary to it. Similarly, when the 12 Step philosophy is adopted by professional treatment programmes (Cook, 1988a,b) it is the spirituality of the process of recovery that is generally distinctive. The spirituality of Alcoholics Anonymous is therefore very much concerned with a re-evaluation of relationships: with self, others and God. It is expressed in non-theological language and in such a way that it neither requires acceptance of nor conflicts with the doctrines and practices of traditional religion, be that Christianity or any other faith. When it comes to God, the emphasis is on a person's own understanding of God – and therefore remains completely open to varied doctrinal possibilities while also emphasising personal experience, willingness to change, and concern for others. The spiritual transformations experienced in Alcoholics Anonymous may be sudden or gradual, although the model set in their 'Big Book' is much more of the former than the latter (Forcehimes, 2004).

Explicitly religious programmes for recovery

In contrast, explicitly religious programmes for recovery from alcohol dependence place somewhat different emphases. It would be misleading to over-generalise. Harold Koenig, in his book on faith and mental health has classified faith-based organisations that deliver mental health services into five different kinds (Koenig, 2005, pp.161–240) and, even within a single faith tradition such as Christianity, there can be widely varying theological understandings of the nature of addictive disorders (Cook, 2006, pp.18–19). What, then, can be said?

Koenig (Koenig, 2005, pp.134–39) has suggested that religion has a positive part to play in mental health treatment generally, for ten reasons. These would also appear to offer a helpful framework for the present specific purpose of considering the way in which the spirituality of explicitly religious responses to alcohol dependence might be beneficial. They could be applied to religious programmes from any of the world's faith traditions. They are listed in Box 22.3 and are followed in each case by quotations from the text of Cecilia Mariz's study of pentecostalism and alcoholism among the Brazilian poor (Mariz, 1991), which provide an example of how they find expression in one particular Christian tradition's understanding of, and response to, the problem of alcoholism.

Box 22.3 Ten reasons for the positive role of religion in mental health (Koenig, 2005) as exemplified in Mariz's study of pentecostalism and alcoholism in Brazil (Mariz, 1991)**1. Religion promotes a positive world view**

'In the Pentecostal church, the action of the Holy Spirit and the gifts of the Spirit offer a positive experience through the creation of an alternative reality without the destructive consequences associated with the abuse of alcohol. The profound sense of total wellbeing produced by conversion in the Pentecostal church helps the alcoholic to achieve initial sobriety and the supports ongoing recovery' (Mariz, 1991, p. 81).

2. Religion helps to make sense of difficult situations

'Addiction to alcohol is the work of the devil as are all other physical and psychological diseases, family conflicts, all sinful behaviour' (Mariz, 1991, p. 78).

3. Religion gives purpose and meaning

'The Pentecostal member, under the influence of the Holy Spirit, experiences a profound religious experience which creates a new province of meaning' (Mariz, 1991, p. 80).

4. Religion discourages maladaptive coping

'In the Pentecostal view, drinking alcohol is morally wrong – a sin; irrespective of the amount, the consumption of alcohol is completely condemned ... Drinking alcohol is not condoned as a legitimate way to celebrate or relax ...' (Mariz, 1991, p. 79).

5. Religion enhances social support

'The recovering alcoholic Pentecostals do not face the temptation of drinking because their fellow church members are neither allowed or encouraged to drink ... The struggle for sobriety ... is a collective struggle, a struggle which involves the entire church community' (Mariz, 1991, p. 79).

6. Religion promotes 'other-directedness'

'Both the devil and the alcohol are outside enemies, the external combat against the devil and against alcohol is a collective struggle in which all the religious community is engaged. The struggle for sobriety is not an individual or personal problem ...' (Mariz, 1991, p. 79).

7. Religion helps to release the need for control

'The devil is stronger than any individual and no one can resist his wiles without the support of God' (Mariz, 1991, p. 78).

8. Religion provides and encourages forgiveness

Surprisingly, forgiveness is not explicitly mentioned by Mariz, but it is clearly central to Pentecostal Christian doctrine, and Mariz notes that the concept of alcoholism encountered here 'places responsibility for recovery on the alcoholics but it does not attack their self-esteem or intensify their guilt' (Mariz, 1991, pp. 78–79).

9. Religion encourages thankfulness

Although thankfulness is also not explicitly mentioned, it is implicitly clear that there is much to be thankful for; see (1) above, for example.

10. Religion provides hope

'The Pentecostal church holds much hope for the poor in Brazil ...' (Mariz, 1991, p. 81).

A similar exercise could be conducted in respect of responses to alcohol dependence offered in other Christian traditions, and other world faiths. Similarly, one could identify under most (if not all) of the ten headings benefits of the 'not religious' but spiritual programme of Alcoholics Anonymous. However, while the latter shares with many explicitly religious approaches the recognition of the unmanageability of life without God, and therefore the need to turn to God for help, it differs in its refusal to address wider issues beyond the process of recovery and it embraces a diversity of personal experiences and doctrinal understandings among recovering alcoholics, rather than focusing on the shared experience and understanding of a single faith tradition. At risk of over-simplifying things, one might argue that Alcoholics Anonymous affirms a common understanding of the spirituality of recovery from addiction, while accepting the diversity of religious views. The explicitly religious approach, in contrast, affirms a common understanding of religious faith, within which the diversity of all other things is understood (including spirituality and recovery from addiction).

Spirituality in the medical healthcare setting

Both the 12-Step programme and the explicitly religious approach to recovery can be offered within medical healthcare settings. However, many medical programmes for people recovering from alcohol dependence do not espouse either a 12-step or religious philosophy. What spiritual interventions may be offered in such settings? It might be argued that no specific intervention of this kind is necessary. Outcomes from purely psychological or medical interventions compare well with the 12-step or religious approaches (Humphreys and Gifford, 2006; Project MATCH Research Group 1997, 1998) and chaplains and other religious leaders are available to those who wish to explore spiritual and religious aspects of their treatment. However, against this, it may be argued that integration of spiritual aspects of treatment with the psychological, social and medical aspects might have advantages and appears to be something that many service users appreciate. Many clergy and religious leaders are not well informed about alcohol dependence and many service users feel ashamed to approach them about their struggles in this area. Similarly, medical staff may have negative attitudes towards 12-step programmes (Day *et al.*, 2005) and antagonistic professional attitudes towards involvement in mutual help groups or faith communities are unlikely to benefit service users.

As an example of the kind of intervention that might be offered in a National Health Service programme in the UK, Jackson and Cook (2005) have provided an account of the introduction of a spirituality group into a community programme for people with drinking problems. The group, very simply, provided a space within which to explore what spirituality meant to its members, and any other relevant matters that arose from this, and was facilitated by two staff members. This had various advantages, including the following:

- It offered the possibility of re-framing struggles with drinking in terms of personal (spiritual) growth.
- It encouraged discussion in a non-defensive manner.
- It allowed discussion of issues which were not being dealt with elsewhere in treatment.
- It was complementary to other (medical, psychological and social) treatments in which service users were engaged.

Various themes emerged during the life of this group, including those of a transcendent dimension to life (or lack of it), drinking-related experiences, relationships, meaning and purpose, and (throughout) personal and shared understandings of what spirituality was all about.

Outcome research

Outcome research related specifically to the treatment of alcohol dependence is only now beginning to address spirituality as an independent or dependent variable and it would appear that this is likely to be an area of growth over coming years. Humphreys and Gifford (2006) identify only three outcome studies of spiritually oriented addiction treatment programmes with longitudinal design, comparison groups, high follow-up rates and reliable/valid measures. Of these, two are studies of alcoholism treatment, and one included treatment of both alcohol and other forms of substance misuse:

1. Taking first the study of the treatment of mixed forms of substance dependence, Humphreys and Moos (2001) studied 1774 addicted veterans treated either in a 12-step orientated programme, or else in a cognitive-behavioural orientated programme. The 12-step programmes focused on the first four steps of Alcoholics Anonymous (as above). Patients in the 12-step group showed higher rates of abstinence at follow-up at 1 year after treatment (45.7 per cent versus 36.2 per cent).

2. The largest randomised controlled trial of alcohol treatments ever conducted, known as Project MATCH, compared the efficacy of 12-step facilitation (TSF) with cognitive-behavioural and motivational enhancement therapy (Project MATCH Research Group, 1997). TSF aimed to encourage involvement in Alcoholics Anonymous and the working of the 12 steps. Outcomes between groups were comparable, with TSF clients faring as well as those in other groups, and with benefits maintained at 3-year follow-up (Project MATCH Research Group, 1998). In fact, outpatients low in psychiatric severity fared rather better in TSF.

3. Rudolf Moos and his colleagues (Moos *et al.*, 1978) studied a Salvation Army treatment programme, a half-way house and a hospital-based programme in the treatment of 'skid row' alcoholics. The spiritual components of the Salvation Army programme included attendance at Alcoholics Anonymous meetings as well as more specifically Christian counselling and services. Alcohol consumption decreased (by 57 per cent) and employment increased (by 55 per cent) in all three treatment modalities.

Various other studies suggest that spirituality may be associated with good outcome. Taking first the research on 12-step programmes, Carroll (1993) found that attendance and practice of step 11 were both correlated with purpose in life and with length of sobriety among members. White *et al.* (White *et al.*, 2001) studied people in recovery from alcohol and other drug problems who were recruited from a variety of treatment settings. They found that their measures of spirituality (the Spiritual Health Inventory, the Surrender Scale, and the Life Orientation Test) predicted both self-perception of the quality of recovery and also the number of steps of the 12-step programme completed. Poage *et al.* (Poage *et al.*, 2004) studied recovering alcoholics attending Alcoholics Anonymous and found that length of sobriety was significantly associated with their measure of spirituality (the Spirituality Assessment Scale). Kubicek and his colleagues (Kubicek *et al.*, 2002) studied 13 subjects with 6 years or more of continuous sobriety, finding

that the two most commonly reported factors that helped to maintain long-term recovery (both among members and people who remitted spontaneously) were willingness to accept help from supportive people and acceptance of help from God or a 'higher power'. Zemore and Kaskutas (2004) found in 194 recovering alcoholics that longer sobriety predicted, among other things, higher levels of spirituality as measured by the Daily Spiritual Experiences scale.

However, the findings of different studies are not consistent. Brown and Peterson (1991) undertook a preliminary study of their instrument for assessing progress in recovery. They showed no correlation between spirituality and length of sobriety in two samples of subjects attending 12-step groups. Rush (2000) found no correlation between length of sobriety and spirituality as measured by the Spiritual Orientation Inventory in a study of 125 women members of Alcoholics Anonymous, although spirituality was associated both with attendance and religious involvement. Furthermore, Borman and Dixon (1998) found that spirituality measured using the Spiritual Well-Being Scale increased during treatment in people attending non-12-step outpatient programmes, as well as in those attending 12-step outpatient programmes.

Less research has been conducted on explicitly religious programmes for people with alcohol dependence. Roland and Kaskutas (2002) found that subjects reporting high attendance as well as high church attendance were more likely to report sobriety over the preceding 30 days after 1 year of treatment than those with high church attendance alone. Torres Stone and her colleagues (Stone *et al.*, 2006) studied 980 Native Americans and found that participation in traditional spirituality had a significant positive effect on alcohol cessation. (In this study, alcohol inpatient treatment did not show a significant effect on alcohol cessation, but the authors speculate that treatment settings may nonetheless have provided an environment within which traditional Native American spirituality was 'socialised'.)

Although not in the same category of research, two other studies are worth reporting here. Shuler *et al.* (Shuler *et al.*, 1994) studied 50 homeless women; they found that 48 per cent reported using prayer as a coping strategy. Significantly fewer of those who used prayer to cope reported drinking in the last 6 months (41.7 per cent versus 69.2 per cent), although history of past drinking problems was similar in each group (25.0 per cent versus 26.9 per cent). This provides a helpful reminder that spirituality is not the exclusive domain of treatment programmes.

In a very different design, Walker *et al.* (1997) conducted a pilot study of intercessory prayer as a randomised adjunct to the treatment for alcohol abuse and dependence of 40 patients admitted to a public treatment facility. No difference between groups was found in alcohol consumption during follow-up. Such a study does not touch on the primary concern of this paper – that of the spirituality of those who receive treatment – but does touch on a whole other domain of research (concerning scientific studies of prayer). However, this rather suggests that spirituality as a component of treatment for alcohol dependence, if it is to be objectively beneficial, needs to be viewed as something requiring active participation, rather than as something that is passively received from others.

What may we observe in relation to these studies overall? First, sample sizes are often small, study designs are often cross-sectional, and the instruments used for measuring spirituality vary widely (see also Cook, 2004). The need for more high-quality studies, of the kind that Humphreys and Gifford identify, is clearly great. Second, even if the findings are somewhat mixed, there is at least sufficient evidence to suggest that further research is warranted and that, perhaps, spirituality will prove to be an important independent and dependent variable in future outcome

studies. Third, there would appear to be a bias towards research emanating from North America, especially that focusing on 12-step spirituality. More studies from other geographical regions, focusing on other spiritual traditions, are greatly needed. Fourth, this research is extremely unsophisticated from a theological viewpoint. Perhaps this is unsurprising, as it is published in scientific journals and has a clearly defined practical purpose in view – that of the provision of effective treatment for alcohol dependence. However, it does raise the question as to whether or not more in depth theological reflection, anchored within particular spiritual traditions, might not better inform future interdisciplinary studies.

Conclusions

Spirituality has become an important concern in academic and clinical discourse on the treatment of drinking problems for various historical and other reasons. While there is continuing debate as to exactly how spirituality should be defined, it touches on important issues that are relevant to the treatment of alcohol dependence: the relationships of the drinker with others and the world around them, their willingness (or otherwise) to recognise their need for help from resources beyond (or within) themselves, the interpretation and meaning which they place on their condition, and the relationship of their struggles with dependence to any pre-existing belief system that they may have adopted or come to own. Given also the growing body of research which suggests that spirituality may influence outcomes, this would appear to be an aspect of clinical care which is important both because it is of concern to service users and because it is associated with an emerging evidence base.

An awareness of the spirituality of Alcoholics Anonymous would appear to represent a fundamental starting point, if only because of the large numbers of alcohol-dependent people who receive help either in local Alcoholics Anonymous groups or else in a professionally led treatment programme based on 12-step principles. However, many people in treatment still have not had contact with Alcoholics Anonymous, or else come to their problems from the perspective of a particular religious tradition, and others engage with faith-based, or explicitly religious, programmes. A wider and positive awareness of the way in which alcohol-dependent people formulate, understand and struggle with the spiritual problems inherent in alcohol dependence is required.

References and further reading

- Abdel-Mawgood, M., Fateem, L. and Al-Sharif, A.I. (1995). Development of a comprehensive treatment program for chemical dependency at Al Amal Hospital, Damman. *Journal of Substance Abuse Treatment*, **12**, 369–76.
- Alcoholics Anonymous (1976). *Alcoholics Anonymous*, 3rd edn. New York: Alcoholics Anonymous World Services.
- Alcoholics Anonymous (1977). *Twelve Steps and Twelve Traditions*. New York: Alcoholics Anonymous World Services.
- Alexander, W. (1997). *Cool Water: Alcoholism, Mindfulness, and Ordinary Recovery*. Boston: Shambhala.
- American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV*, 4th edn. Washington DC: American Psychiatric Association.

- Barrett, M.E. (1997). *Wat Thamkrabok*: A Buddhist drug rehabilitation program in Thailand. *Substance Use and Misuse*, **32**, 435–59.
- Berenson, D. (1990). A systemic view of spirituality. *Journal of Strategic and Systemic Therapies*, **9**, 59–70.
- Bien, T. and Bien, B. (2002). *Mindful Recovery: A Spiritual Path to Healing from Addiction*. New York: Wiley.
- Borman, P.D. and Dixon, D.N. (1998). Spirituality and the 12 steps of substance abuse recovery. *Journal of Psychology and Theology* **26**, 287–91.
- Brown, H.P. and Peterson, J.H. (1991). Assessing spirituality in addiction treatment and follow-up: Development of the Brown–Peterson Recovery Progress Inventory (B-PRPI). *Alcoholism Treatment Quarterly*, **8**, 21–50.
- Carroll, S. (1993). Spirituality and Purpose in Life in alcoholism recovery. *Journal of Studies on Alcohol*, **54**, 297–301.
- Cook, C.C.H. (1988a). The Minnesota model in the management of drug and alcohol dependency: miracle method or myth? Part I. The philosophy and the programme. *British Journal of Addiction*, **83**, 625–34.
- Cook, C.C.H. (1988b). The Minnesota model in the management of drug and alcohol dependency: miracle method or myth? Part II. Evidence and conclusions. *British Journal of Addiction*, **83**, 735–48.
- Cook, C.C.H. (2004). Addiction and spirituality. *Addiction*, **99**, 539–51.
- Cook, C.C.H. (2006). *Alcohol, Addiction and Christian Ethics*. Cambridge: Cambridge University Press.
- Day, E., Gaston, R.L., Furlong, E., Murali, V. and Copello, A. (2005). United Kingdom substance misuse treatment workers' attitudes toward 12-step self-help groups. *Journal of Substance Abuse Treatment*, **29**, 321–27.
- Dollard, J. (1983). *Toward Spirituality*. Minnesota: Hazelden.
- Edwards, G. and Gross, M. (1976). Alcohol dependence: Provisional description of a clinical syndrome. *British Medical Journal* **1**, 1058–61.
- Fetzer Institute and National Institute on Aging Working Group (1999). *Multidimensional Measurement of Religiousness/Spirituality for Use in Health Research*. Kalamazoo: Fetzer Institute.
- Forcehimes, A.A. (2004). *De profundis*: Spiritual transformations in Alcoholics Anonymous. *Journal of Clinical Psychology*, **60**, 503–17.
- Garrett, M.T. and Carroll, J.J. (2000). Mending the broken circle: Treatment of substance dependence among Native Americans. *Journal of Counseling and Development*, **78**, 379–88.
- Hill, P.C. and Hood, R.W. (eds) (1999). *Measures of Religiosity*. Birmingham AL: Religious Education Press.
- Honderich, T. (ed.) (1995). *The Oxford Companion to Philosophy*. Oxford: Oxford University Press.
- Humphreys, K. and Gifford, E. (2006). Religion, spirituality and the troublesome use of substances. In: W.R. Miller and K. Carroll (eds), *Rethinking Substance Abuse: What the Science Shows and What We Should Do About It*. New York: Guilford, pp. 257–74.
- Humphreys, K. and Moos, R. (2001). Can encouraging substance abuse patients to participate in self-help groups reduce demand for health care? A quasi-experimental study. *Alcoholism: Clinical and Experimental Research*, **25**, 711–16.
- Jackson, P. and Cook, C.C.H. (2005). Introduction of a spirituality group in a community service for people with drinking problems. *Journal of Substance Use*, **10**, 375–83.
- James, W. (1985). *The Varieties of Religious Experience*. Harmondsworth: Penguin Classics.
- Koenig, H.G. (2005). *Faith and Mental Health*. Philadelphia: Templeton Foundation Press.
- Kubicek, K.R., Morgan, O.J. and Morrison, N.C. (2002). Pathways to long-term recovery from alcohol dependence: Comparison of spontaneous remitters and AA members. *Alcoholism Treatment Quarterly*, **20**, 71–81.
- Kurtz, E. (1991). *Not-God: A History of Alcoholics Anonymous*. Center City: Hazelden.
- Mariz, C.L. (1991). Pentecostalism and alcoholism among the Brazilian poor. *Alcoholism Treatment Quarterly*, **8**, 75–82.
- May, G.G. (2000). The nature of addiction. *The Way*, **40**, 303–13.
- Mental Health Foundation (2002). *Taken Seriously: The Somerset Spirituality Project*. London: Mental Health Foundation.
- Mercadante, L.A. (1996). *Victims and Sinners*. Louisville: Westminster John Knox Press.
- Miller, W.R. (1998). Researching the spiritual dimensions of alcohol and other drug problems. *Addiction*, **93**, 979–90.

- Moos, R.H., Mehren, B. and Moos, B. (1978). Evaluation of a Salvation Army alcoholism treatment program. *Journal of Studies on Alcohol*, **39**, 1267–75.
- Morgan, O.J. (2002). Alcohol problems, alcoholism and spirituality: An overview of measurement and scales. *Alcoholism Treatment Quarterly*, **20**, 1–18.
- Moss, R., Cook, C.C.H. and Sandoz, J. (2007). Maintenance and relapse prevention. In: D. Capuzzi and M.D. Stauffer (eds), *Foundations of Addictions Counseling*. Boston: Pearson, pp. 268–282.
- Poage, E.D., Ketzenberger, K.E. and Olson, J. (2004). Spirituality, contentment, and stress in recovering alcoholics. *Addictive Behaviors*, **29**, 1857–62.
- Powell, A. and Cook, C.C.H. (2006). Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists. *Reaching the Spirit: Social Perspectives Network Study Day*. Paper 9, pp. 34–35.
- Project MATCH Research Group (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH post-treatment drinking outcomes. *Journal of Studies on Alcohol*, **58**, 7–29.
- Project MATCH Research Group (1998). Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes. *Alcoholism: Clinical and Experimental Research* **22**, 1300–11.
- Ringwald, C.D. (2002). *The Soul of Recovery: Uncovering the Spiritual Dimension in the Treatment of Addictions*. Oxford: Oxford University Press.
- Roland, E.J. and Kaskutas, L.A. (2002). Alcoholics Anonymous and church involvement as predictors of sobriety among three ethnic treatment populations. *Alcoholism Treatment Quarterly*, **20**, 61–77.
- Rush, B. (1943). An inquiry into the effects of ardent spirits on the human body and mind with an account of the means of preventing and of the remedies for curing them. *Quarterly Journal of Studies on Alcohol*, **4**, 325–41.
- Rush, M.M. (2000). Power, spirituality, and time from a feminist perspective: Correlates of sobriety in a study of sober female participants in Alcoholics Anonymous. *Journal of the American Psychiatric Nurses Association*, **6**, 196–202.
- Sandoz, J. (2004). *Exploring the Spiritual Experience in the 12-step program of Alcoholics Anonymous: Spiritus Contra Spiritum* (Studies in Religion and Society, 67). Lewiston: Edwin Mellen Press.
- Sheldrake, P. (ed.) (2005). *The New SCM Dictionary of Christian Spirituality*. London: SCM.
- Shuler, P.A., Gelberg, L. and Brown, M. (1994). The effects of spiritual/religious practices on psychological well-being among inner city homeless women. *Nurse Practitioner Forum*, **5**, 106–13.
- Stone, R.A., Whitbeck, L.B., Chen, X., Johnson, K. and Olson, D.M. (2006). Traditional practices, traditional spirituality, and alcohol cessation among American Indians. *Journal of Studies on Alcohol*, **67**, 236–44.
- Trotter, T. (1988). *An Essay, Medical, Philosophical, and Chemical On Drunkenness and Its Effects On the Human Body*. London: Routledge.
- Vaillant, G.E. (1983). *The Natural History of Alcoholism: Causes, Patterns, and Paths to Recovery*. Cambridge MA: Harvard.
- Walker, S.R., Tonigan, J.S., Miller, W.R., Comer, S. and Kahlich, L. (1997). Intercessory prayer in the treatment of alcohol abuse and dependence: A pilot investigation. *Alternative Therapies in Health and Medicine*, **3**, 79–86.
- White, J.M., Wampler, R.S. and Fischer, J.L. (2001). Indicators of spiritual development in recovery from alcohol and other drug problems. *Alcoholism Treatment Quarterly*, **19**, 19–35.
- World Health Organization (1992). *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*. Geneva: World Health Organization.
- Zemore, S.E. and Kaskutas, L.A. (2004). Helping, spirituality and Alcoholics Anonymous in recovery. *Journal of Studies on Alcohol*, **65**, 383–91.